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1. *PSYCHIATRIC REPORT OF STUART GRASSIAN, M.D., 2012 Misc. Filings LEXIS 7603*
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PSYCHIATRIC REPORT OF STUART GRASSIAN, M.D., 2012 Misc. Filings LEXIS 7603

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF KANSAS

Case number: 6:09-cv-01278

September 11, 2012

Reporter
2012 Misc. Filings LEXIS 7603 *

Ronell Richard v. Board of County Commissioners of Sedgwick County, et al.

Expert Name: Dr. ***STUART*** EDWIN ***GRASSIAN***, , M.D.; MOLLY VIRGINIA ALLEN, , M.D.

Text

In Re: Richard v. Hinshaw, et al

Psychiatric Report

1. Introduction, Background

My name is ***Stuart Grassian***, M.D. I am a Board-certified psychiatrist, licensed to practice medicine **[*2]** in the Commonwealth of Massachusetts. I have extensive experience in evaluating the mental health services afforded to mentally ill inmates in jails and prisons, as well as the impact of the use of isolation -- solitary confinement -- in the management of mentally ill inmates.

I was a psychiatric expert in *Coleman v. Wilson, 912 F.Supp. 1282 (E.D. Cal., 1995)*; finding that the mental health care afforded prisoners in California -- including the extensive use of solitary confinement with mentally ill inmates -- violated the 8th and 14th Amendments to the U.S. Constitution. The Court's findings were affirmed by the United States Supreme Court in 2011, sub nom Brown v. Plata. The Coleman Court's findings included that the inadequate training of correctional staff regarding mental illness created an unconstitutional risk of abusive treatment of inmates. It also found that the defendants use of segregated confinement "to house mentally ill inmates violated the Eighth Amendment because … such placement will cause further decompensation, and because inmates are denied access to necessary mental health care while they are housed in … segregation."

My observations **[*3]** and conclusions generally regarding the psychiatric effects of solitary confinement, and the adequacy of mental health care to inmates who are, or become mentally ill, have been cited in a number of federal court decisions, for example: *Davenport v. DeRobertis, 844 F.2d 1310 (7th Cir. 1988)*, and *Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal. 1995)*.

I prepared a written declaration for Madrid describing the medical literature and historical experience concerning the psychiatric effects of restricted and isolated conditions of confinement as well as of other conditions of restricted environmental and social stimulation, and subsequently prepared the general (non-institution specific) and non-redacted (non-inmate specific) portions of that declaration into a general statement, which I have entitled Psychiatric Effects of Solitary Confinement, 22 Wash. U. Journal of Law & Policy (2006). This paper is attached hereto and incorporated herein. It describes the extensive body of literature, including clinical and experimental literature, regarding the effects of decreased environmental and social stimulation, and more specifically, observations concerning the **[*4]** effects of segregated confinement on prisoners.

I have given lectures and seminars regarding these issues. Although I do not have a complete list of those lectures and seminars, they include, but are not limited to, lectures at Harvard Medical School-Beth Israel Hospital, Boston, at meetings of the Nova Scotia, Virginia and New York State Bar Associations, The Office of Military Commissions of the U.S. Department of Defense, The Federal Capital Defenders Habeas Unit and The Correctional Association of New York, as well as, invited testimony before state legislative hearings in New York, Massachusetts and Maine. I have been retained as an expert in class-action lawsuits regarding these issues in Massachusetts (2), New York (3), California (2), Kentucky, Michigan, Ohio, Texas and Florida, as well as individual cases in other states, including California, Connecticut, Florida, Georgia, Maine, Massachusetts, New Mexico, New York, Pennsylvania, Texas, Virginia and the State of Washington. I have been retained and consulted by a variety of public advocacy groups, including The Legal Aid Society of New York, Prisoner's Legal Services of New York, the Center for Constitutional Rights, **[*5]** The Massachusetts Correctional Legal Services, The Massachusetts Civil Liberties Union, the National Prison Project of the American Civil Liberties Union, and the Department of Corrections of the State of Florida.

Since the tragic events of September 11, 2001, I have also been consulted regarding the confinement of a number of individuals who were deemed to be "enemy combatants" and/or were either charged with or convicted of conspiring against the United States. These include individuals who were confined in Guantánamo, in the Navy Brig in Charleston, S.C., in the Federal ADX prison in Florence, Colorado and in the SeaTac facility in Seattle, Washington, as well as in federal detention centers in New York City and Miami, Florida.

In the present matter, I was retained by attorneys for the Estate of Edgar Richard, Jr. to evaluate the quality of care that Mr. Richard received at Sedgwick County Jail during the period of October 31, 2007 through February 15, 2008, and to evaluate, whether and to what extent, Mr. Richard suffered emotional harm as a result of his treatment at the Jail. A copy of my C.V. is attached hereto, as is a list of cases in which I have testified **[*6]** over the past four

years. My fee for all professional services in this matter, including record review, preparation of report, testimony, etc. is $ 360 /hour. (Since being retained in this matter, my fee for new matters increased to $ 400/hour.) I am available for a deposition with reasonable notice at my office located at 401 Beacon Street, Chestnut Hill, MA 02467 or, if necessary, at a suitable and reasonably located court reporter's office.

The following report is based upon my review of documents and records provided by the attorneys. A list of these is attached hereto. Those records are extremely voluminous, as a result, I have not included each and every basis for my opinions. However, this report is quite long and detailed, and I believe provides a more than adequate basis for the conclusions I reach. I reserve the right to modify any opinion upon the presentation of new evidence; if that were to occur, I would prepare a supplemental report describing those new or modified opinions.

2. Brief Summary of Factual Issues.

Edgar Richard, Jr. was a mentally ill and disabled man who suffered with chronic severe mental illness, diagnosed with either schizophrenia or schizoaffective **[*7]** disorder. At times when his illness flared up, he would be agitated, verbally abusive or threatening (albeit people who knew him well came to ignore such verbal flareups as not leading to any physical aggression). At times his thinking and speech would be incoherent. He would experience hallucinations and the delusional belief that he was "the Black Jesus". During the course of his life, he had been hospitalized on a number of occasions, although he had enjoyed significant periods of time where he was able to function adequately in the community, albeit with support. [1] From January 2003 until he was imprisoned in late October 2007, he received support for independent living through The Breakthrough Club in Wichita. The records from that program reveal just how well he could function for large periods of time with appropriate support. He could be friendly, eager to please, willing to help around the Club (e.g. taking out the trash regularly, picking up the chairs, etc.), and able to reach out for and accept help in problem-solving the ordinary tasks of living. On the occasions when he did decompensate, he was able to restabilize back into the community through a combination of Breakthrough **[*8]** Club and Comcare Crisis Services, and relatively brief psychiatric hospitalization. The record suggests caring and appropriately helpful services, with very good results.

During the almost five year period covered by the Breakthrough Club records, he decompensated only three times. Each time, failure to take his psychiatric medication was the predominant, or at least a major cause of the decompensation. During such periods of decompensation, he was generally depressed and psychotic, and sometimes hostile and verbally threatening; he never, however, became physically violent. The second episode led to a brief period of imprisonment, but then release on parole, and a return to services through the Breakthrough Club.

Unfortunately, **[*9]** during the last of these three episodes, while once again quite evidently psychotic, he was alleged to have again became verbally threatening and, at least acutely, was unable to be managed at Good Shepherd Hospital, where he was initially committed. Because of the behavioral problems he was then presenting, a decision was made to exercise the authority under his conditions of parole and transfer him to the Sedgwick County Jail. It is perplexing as to why this decision was made, as opposed to the more obvious one of transferring him to the more secure Osawatomie State Hospital where he could have received proper management of his illness. In any event, on October 31, 2007 he was transferred from Good Shepherd Hospital to the Sedgwick County Jail and to the care and treatment of Conmed, Dr. Murphy and Dr. McNeil.

Mr. Richard remained at Sedgwick County Jail until the brutal beating he suffered on February 15, 2008. While the beating itself was clearly unconscionable, and the perpetrator was ultimately convicted of a crime for it, Mr. Richard's unconscionable suffering at the jail started much earlier -- indeed, from the beginning of his incarceration.

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[1] Osawatomie State Hospital (121196-121495); Breakthrough Club (A19000-A19099); Comcare 111006-111007, 111036, 111048, 111095-111096, 111105,111112, Error! Main Document Only.111118-111121, 111301-111306); Report of Molly Allen, M.D. (A30000-A30100); Conmed Records (A01001-A01050)

Given how psychiatrically **[*10]** disturbed he was even before arriving at the jail, it is not surprising that within just a few days after he was incarcerated, his behavior was noted to be "bizarre." [2] Clearly, he needed to be transferred to a psychiatric hospital so that he could be put back on his medication and thus given the opportunity to recompensate. Instead he was placed in solitary confinement ("racked watch") as a means of "managing" him. Yet what did that decision actually amount to? "Managing" the manifestations of his mental illness was ultimately the antithesis of treating it. By placing him in segregation, no matter how psychotic he became, no matter how bizarre his behavior might become, he was controlled physically. But this isolated and solitary confinement would inevitably amount to control at the expense of rehabilitation. A psychiatric hospital would have been the most therapeutically helpful and appropriate environment for him at that time. On the other hand, it is and was then well-recognized that solitary confinement is the most psychologically destructive environment in which he could have been placed. Yet he remained there, in solitary confinement, until finally, on February 15, 2008, he **[*11]** was beaten to unconsciousness by defendant Diaz.During the months of his incarceration, he inexorably became increasingly psychiatrically ill. [3] Over time he became increasingly non-compliant with his antipsychotic, mood-stabilizing and sedative medications, and well before the beating, his mental state had deteriorated greatly. [4] His behavior had become increasingly bizarre -- up all night screaming and yelling, shouting that he was the Black Jesus, banging and kicking his cell door, tearing toilet paper into little pieces and dancing around them in a wild fashion, urinating and defecating on the cell floor and living with that filth, and so forth. [5] He was subjected to abuse and humiliation by other inmates and by jailers as well, and the other imnates were becoming increasingly enraged at him for preventing them from sleeping at night. [6] They insulted him about his mental illness, with racial slurs and his food was sprayed with chemicals and spit on. **[*12]** Both other inmates and jailers would from time to time place paper over the small window in his cell facing out onto the tier so that he could see nothing out of his cell. [7] **[*13]** And Mr. Richard was apparently not the only mentally impaired inmate living in his own filth. In her sworn statement, Sergeant Yolanda Collins stated: "I visited the ConMed Clinic during 2007 and 2008 and after. I observed a horrible disgusting odor coming from certain cells. It was open and obvious … Dr. Murphy, Dr. McNeil and anyone who worked for the Sheriff's Department or ConMed had to know that those cells were not sanitary and stunk like urine and feces. There were inmates that regularly played with their feces and ConMed allowed that to occur. This practice was before, during, and after Edgar Richard." [8] Ms. Collins stated in her deposition that there was an atmosphere of abuse aimed at the mentally ill and disabled for over 15 years. [9] This was also confirmed by inmate Walter Beans who observed the clinic cells while a trustee. He advised the clinic cell smelled of urine and feces. [10] **[*14]** 3. Psychiatric Issues Presented in Richard v. Hinshaw

I anticipate that I may be asked to testify about one or both of the following issues:

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[2] Sgt. Freeman email of 11/05/07 (010155)

[3] Inmate Log 10/31/07-02/15/08 (SG2022-SG2036); Inmate Observation Form (SG2019-SG2021); DAL 02/15/08 (SG79-SG89); Conmed Records (A01001-A01050)

[4] Medication Administration Record (010064, 010067- 010069, 010068, 010069, 010071, 010072, 010116; Conmed Chart (A01000-A01050); Depo. Beans, P.59-60, L.143; Depo. Dr. McNeil, P.228; Stmt Ward 04.22.12

[5] DAL 02/15/08 (SG79-SG89); DAL 02/15/08 (SG324-SG326); Inmate Log 10/31/07-02/15/08 (SG2022-SG2036); Depo. Beans, P.30-33; Stmt Darby (B04175-B04176); Stmt Anderson (B04561-B04565); Stmt Ates (B05000-B05010); Stmt McCoy (SG776); Stmt Gaston (B04381-B04382); Stmt Kraai (B05020); Deputy Jordan email of 02/27/08 (SG4277); Depo. McCoy, P. 10; Depo. Dr. Murphy, P. 241-242.; Stmt Ward 04/22/12

[6] Depo. McCoy, P.19-20, 170-171; Depo. Beans, P.32-33, 39-40, 47-49, 86, 143-144; Stmt Darby (B04175-B04176); Stmt Anderson (B04561-B04565); Stmt Leal-Anderson (B05031); Stmt Deputy Nelson (SG700-SG772);Stmt Gaston (B04381-B04382); Stmt Kraai (B05020); Depo. Beans, P. 32-33, 39, 40, 47-48, 143-144

[7] Depo. Beans, P.86; Stmt Sgt. Collins 05/09/12

[8] Stmt Sgt. Collins 05/09/12

[9] Depo. Collins, P. 22, 37

[10] Depo. Beans, P.26-29

. Liability: My opinion as to any violations of the standard of care in the mental health response to Mr. Richard during his incarceration in the Sedgwick County Jail.

. Damages: My opinion as to the emotional harm that he suffered as a result of his conditions of incarceration and of his beating on February 15, 2008.

4. Mental Health Response to Mr. Richard During his Incarceration at the Sedgwick County Jail.

The Jail administration and its detention staff, ConMed, Dr. Murphy, and several other named defendants demonstrated an unconscionable disregard of their responsibilities to Mr. Richard, a person with both mental disability and serious mental illness:

4.1 Placing and Retaining Mr. Richard in Segregation.

As described in my Washington University article, attached, there is a substantial body of literature describing serious psychiatric effects of solitary confinement and of other situations involving **[*15]** deprivation of perceptual or occupational stimulation, or social isolation. The issue has been of significant concern in various medical situations as well as in the use of segregation in prison.

ConMed essentially acknowledged this problem. According to multiple witnesses, one of their policies required that a mental health evaluation be completed on a daily basis for all inmates in segregated housing, and that a form be completed and placed in the inmate's chart on a daily basis documenting this evaluation. [11] Yet the evidence suggests that this was a policy that was not in fact put into practice. Edgar Richard, Jr.'s chart does not contain their daily documented examinations and no satisfactory explanation for the absence has been advanced. There is a substantial question as to whether this "policy" was meant to have any real, substantive effect, or whether it is mere window-dressing. Depositions in this case demonstrate not only that the forms were rarely filled out, but also that no one who should read them does so, and no one ever audits whether they are actually completed. [12]

[*16] In his deposition, Dr. Paul Murphy, ConMed's mental health director at the Sedgwick County Jail, acknowledged that he knew of the policy, but claimed he was never taught anything about it by ConMed after he contracted to work for the company, and that despite his claim that he read patients' charts regularly, he never even noticed whether the required forms existed in the chart, or what they might reveal. [13] In a shocking dismissal of clinical responsibility, he claimed that this policy and its proper implementation, had nothing to do with him, that it was not relevant to him. [14] In short, it was a "policy" without any training to understand its import, or to make sure that it was being followed.And in **[*17]** a complete abdication of his clinical responsibility, Dr. Murphy claimed it had nothing to do with him -- hence, nothing to do with his responsibility to take care of the mentally ill imnates at Sedgwick Jail. In short, it was merely window dressing for ConMed, which had hired a psychiatrist who was similarly unconcerned with its relevance. The failure of ConMed to make that policy have any substantive import does not excuse Dr. Murphy or Conmed. Although he had the ultimate responsibility for the mental health care in the jail, in his deposition he displayed a disregard of those responsibilities. He continually tried to narrow the scope of his responsibility, utterly failing to recognize that it was he who was directly responsible to insuring that mental illness was treated, and not exacerbated, during incarceration. [15]In regard to the issue of solitary confinement, Dr. Murphy **[*18]** claimed as a general proposition that segregation did not pose any substantial risk of psychological harm, and he also claimed -- incorrectly - that there was no published literature concerning the issue. [16] He was

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[11] Depo. Dr. Murphy, P.177-179, 214, 283; Depo. Armstrong, P.45, 79, 126, 130-131, 135-136, 213; Depo. Barnt, P.61-63; Depo. Haubersten, P.18

[12] Depo. Barnt, P.61-62; Depo. Hall, P.63; Depo. Dr. Murphy, P. 177-178, 185, 208-209, 263; Depo. Armstrong, P. 135-136

[13] Depo. Dr. Murphy, P. 21, 155-156, 185, 208, 263.

[14] Id., P. 177-178

[15] Id., P. 96-97, 101, 125, 177-178, 218-223, 241-242, 249, 260, 266, 293-294, 302, 306-308, 332, 342-343, 350-351, 356-357

[16] Id., P.175-178

wrong, but more than that, he demonstrated a disturbing lack of interest in knowing anything about the issue. Indeed, if he knew that there was a ConMed policy purporting to require close monitoring of the psychiatric status of inmates in segregated confinement (i.e. every 30 minutes), did he have no responsibility to find out why that condition of confinement required such intense psychiatric observation?Dr. Murphy showed he cared little to learn of the effects of solitary confinement. Indeed, in his deposition, he declared that it made little difference just how much psychiatric deterioration a mentally ill inmate experienced while in segregation; when he was asked about Edgar Richard's severe deterioration at Sedgwick Jail, he blithely claimed it would cause him no lasting **[*19]** harm. He even declared, without any basis at all, the rather stunning proposition that Mr. Richard's condition would actually improve with solitary confinement, and certainly would not deteriorate. [17] This assertion is in fact not just untenable, it is literally shocking. Discovery in this case has established that Mr. Richard's deterioration in segregated confinement was obvious to virtually anyone who had any contact with him. [18] In his deposition, even Dr. McNeil, the nominal head of all medical services at the Jail, acknowledged that Mr. Richard's condition deteriorated while he was housed in segregation. [19] **[*20]** In the end, how could Dr. Murphy have even ventured an opinion on the subject? In her deposition, Yolanda Collins testified that Dr. Murphy never even visited the prisoners in segregated housing (Collins dep at 96). Yet, despite this, Dr. Murphy ultimately did have an opinion about the likely effects of solitary confinement. It is an opinion squarely at odds with the medical literature, but then, Dr. Murphy had not troubled himself to read that literature, he had not troubled to find out why there was an expectation of very frequent psychiatric observation of inmates in such confinement, and in perhaps the deepest explanation of all, he opined that it made little difference how much a mentally ill inmate such as Mr. Richard suffered psychiatrically while in segregation. [20]

4.2 The Jail's **[*21]** Culture and Milieu: Failure to Educate Jail Staff, to Foster Understanding Rather than Contempt, Towards the Mentally Ill Inmate.

Sedgwick County Jail has a written policy (General Order 117.01) requiring that mental health problems must be addressed in a professional manner to reduce crisis in the facility. [21] The Order requires that deputies notify a supervisor when presented with an inmate exhibits depression, anxiety, psychosis, or any abnormal behavior. The Order also requires supervisor notification of court ordered evaluations. Additionally, the Order provides that if a situation cannot be treated within facility, arrangements will be made to provide appropriate care. [22] In reality, however, the Order is little more than window dressing. In fact, Sergeant Collins testified that polices of the jail while she was there for over sixteen years were just window dressing and were routinely ignored. [23]

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[17] Id., P.224

[18] Depo. Barnt, P.84-85, 87; Depo. Beans, P.30-31, 59-60; Sgt. Freeman email of 11/05/07 (010155); Depo. Hall, P.121-122, 135-137, 141-147, Depo. Holtz, P.132; Depo. Leu, P.126, Depo. Link, P.14, 34-35, Depo. McCoy, P.10-11; Depo. Dr. Murphy, P.265-266, 305-306, 324-325, 328-329, 331-332; Depo. Nelson, P.30-31; Depo. Novak, P.68-69, Inmate Log 10/31/07-02/15/08 (SG2022-SG2036); Inmate Observation Form (SG2019-SG2021); DAL 02/15/08 (SG79-SG89), Stmt Ward 04.22.12, DAL 02/15/08 (SG324-SG326); Inmate Log 10/31/07-02/15/08 (SG2022-SG2036), Depo. Beans, P.30-33; Stmt Darby (B04175-B04176); Stmt Anderson (B04561-B04565); Stmt Ates (B05000-B05010); Stmt McCoy (SG776); Stmt Gaston (B04381-B04382); Stmt Kraai (B05020); Deputy Jordan email of 02/27/08 (SG4277); Depo. McCoy, P. 10, Conmed Chart (A01000-A01050)

[19] Depo. Dr. McNeil, P.202, 228

[20] Psychiatric Effects of Solitary Confinement, 22 Wash. U. Journal of Law & Policy (2006)

[21] Sedgwick County Jail, General Order, 117.01 -- Mental Health Services

[22] Id.

[23] Depo. Sgt. Collins, P.106-107

Multiple depositions in this case confirm that ConMed made little to no effort to educate staff about mental illness, to help them understand the agony of mental illness. [24] Thus, ConMed failed to address the obvious consequence of having untrained, uneducated people dealing on a day by day basis with people whose behavior was so bizarre as to be unpredictable and hence frightening and enraging. **[*23]**

Sheriff Steed and then Undersheriff Hinshaw's unacceptable policies, customs and practices were described in some detail in Sergeant Collins' statement. She described witnessing many instances of inmates beating other inmates, or deputies using excessive force with inmates. Sheriff Steed and then Undersheriff Hinshaw's response was at best one of total disregard of the effect of this toxic environment on inmate mental health: "A custom and routine existed to allow some inmates to be beaten or roughed up. … It was discussed openly in squad rooms… When inmates made complaints about violence done to them by another inmate, the practice was to do as little as possible or nothing and ignore it." [25] Other statements, including those of Timothy Gibfried and Sedrick Ates support her observations of the pervasive atmosphere of violence and cruelty at Sedgwick County Jail. [26]Ms. Collins also stated that although **[*24]** there was a "policy" of not abusing and insulting the mentally ill or otherwise impaired, doing so was entirely open and routine at the jail: "It was done basically for entertainment." Mentally impaired inmates were referred to routinely as "retards," "idiots," "mentals," "crazies," and so forth. Such behavior was not hidden; it was open and notorious -- indeed, it was applauded. [27] She describes repeatedly how open was the culture of abuse of mentally ill inmates at the Jail. [28]One of the two squads chose to call itself "team short bus," "and they made up songs and slogans that ridiculed the mentally ill. This singing and chanting occurred in the squad room before, during and at the conclusion of meetings. This was done openly. … They had a contest. They drew pictures [of a short bus] and decorated them with misspelled wards and words written backwards to ridicule the mentally ill and retarded. This "art" was displayed and **[*25]** shown openly. It was on display in the Watch Commander's Office." Ms. Collins stated that many officers -- Majors, Watch Commanders, Captains, Lieutenants and Sergeants -- used that office for lunch or other purposes while this "art" was on display. The contest had been initiated by a Sergeant Taylor, who was later promoted to Lieutenant. And the "winner" was chosen by Undersheriff Michael Stover, the second in command of the Jail. [29] In her deposition, Ms. Collins states that the chart was designed to ridicule mentally disabled persons. [30]In short, the ridicule of the mentally impaired had become an open and notorious practice at the Jail before Mr. Richard's arrival there, and continued well after his beating. Ms. Collins eventually filed a complaint about it in November 2011. She states that as a result of doing so, she was ostracized and treated coldly by her peers. [31] **[*26]**

Other Jail employees and Conmed staff alluded to the conduct as well. Many openly acknowledged mentally ill inmates were the subject of bullying and referred to in derogatory manners. [32] Deputy Nelson testified she heard inmates described as "mental." [33] Sgt. Burke testified she knew of no training or ever being told not to condone

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[24] Depo. Armstrong, P.1-6, 121, 143-144; Depo. Barnt, P.31-32, 44-46, 53-54, 56-57, 79, 82-83, 85-87; Depo. Woutzke, P.10-12, 28-29, 30, 51-53; Depo. Leu, P.8, 45, 52, 56, 64-65, 72-74; Depo. Dr. McNeil, P.101, 106, 115-116, 146, 165, 167-168, 178, 205; Depo. Dr. Murphy, P.158-159, 175, 177-178, 211, 217, 264-267, 270, 302, 306-307, 350-351; Depo. Novak, P.38-39, 73-74, 79, 137, 139-140, 182, 192; Depo. Fletcher, P.12, 14-20, 41, 61, 76-77, 80-81, 90-91; Depo. Hall, P.49, 54, 97-98, 99-100, 134-135, 177; Depo. Skelton, P. 17, 21-22, 24-25, 41-42, 48, 67-68, 78-79, 117; Depo. Wolf, P.26, 60, 61, 73-77, 93, 129-130

[25] Stmt. Sgt. Collins 05/09/12

[26] Stmt. Timothy Gibfried; Stmt. Sedrick Ates

[27] Stmt. Sgt. Collins 05/09/12

[28] Depo. Sgt. Collins, 102-105

[29] Stmt. Sgt. Collins 05/09/12

[30] Depo. Sgt. Collins, P. 30

[31] Stmt. Sgt. Collins 05/09/12

[32] Depo. Barnt, P.16; Depo. Leu, P.50-51, 52, 64-65, 77-78, 137-138, 147-148; Stmt Leu (SG536); Depo. Skelton, P.47-48

[33] Depo. Deputy Nelson, P.113

brutal or inhumane treatment of others. [34] Sheriff Hinshaw testified he had no recollection of any investigation into how mentally ill inmates are treated in the jail. [35] Major Michael Oliver himself referred to Edgar Richard, Jr. as a "mental" in an internal email. [36]And once again, Dr. Murphy, the person ConMed hired as director of mental health services at the Jail, simply attempted **[*27]** to narrow and disavow his responsibility: In his deposition, he claimed that the housing of mentally ill inmates was not his concern, nor was the fact that mentally ill inmates were vulnerable to abuse and humiliation in confinement Specifically, he testified it was "common knowledge" that Edgar Richard, Jr. was abused by fellow inmates. [37] Dr. Murphy, in fact did not see it as within his scope of responsibility to know whether mentally ill inmates were being abused (for example, by simply talking with them about their experience at the prison), let alone to do anything to attempt to ameliorate this problem. [38]Yet the training of any psychiatrist inevitably involves treating seriously disturbed individuals in hospitals, and thus learning that the milieu in which treatment is done is a critical factor in patient outcome. Indeed, there is a great emphasis on in-service education of hospital staff. Only by some **[*28]** understanding of the agony of mental illness can staff overcome their instinctive fear and aversion to the bizarre, often frightening, behavior of the mentally ill. Without such education, there will likely be fear, and contempt, for the severely mentally ill patient. Dr. Murphy thus must have known that without such education, there would be an inexorable tendency towards a fearful, contemptuous, ultimately sadistic approach to the mentally ill. Yet he entirely failed to respond to this reality, never to inquire about it, never to attempt to do anything to ameliorate it. He did not even know whether the deputies received any education regarding mental illness. [39] He was there just to order medication, not to care about the patient.

4.3 Response to Medication Non-Compliance, Treatment of an Individual Incompetent to Make Decisions Regarding his Need for Treatment, Response to Urgent Situations.

In his deposition, Dr. Murphy asserts that ConMed provided him **[*29]** no training whatsoever regarding the issues presented in caring for mentally ill individuals in a correctional setting. [40] If Dr. Murphy's assertion here is correct, it was utterly inexcusable for ConMed to fail to provide such education, especially insofar as the legal situation of an inmate might possibly change the approach to providing proper treatment.

One of these issues was the procedure for medicating patients who lacked capacity and were not competent to make decisions regarding their need for such treatment. Because the United States Constitution requires that the incarcerated mentally ill receive reasonably adequate treatment for their mental illness, it inevitably follows that those mentally ill inmates in need of treatment but incompetent to make treatment decisions be provided a means by which such treatment-decision incompetence can be adjudicated, and then appropriate treatment can be provided over objection. Conmed had a duty to educate Dr. Murphy regarding this **[*30]** fundamental issue. Their failure contributed to Edgar Richard, Jr.'s lack of treatment and resultant injuries.

In most jurisdictions, treatment over objection cannot either be provided, or at least begun, in the prison setting. Thus, the adjudication that a person is incompetent to make decisions about his treatment will usually result in the transfer of the inmate to a forensic psychiatric hospital. [41] It was critical for anyone choosing to serve as director of mental health services at the Sedgwick County Jail to understand the procedures required to effect such treatment over objection. As Judge Ballinger declared, doctors in a correctional setting always have the authority to transfer

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[34] Depo. Sgt. Burke, P.136-137

[35] Depo. Sheriff Hinshaw, P.107

[36] Depo. Major Oliver, P.91-92

[37] Depo. Murphy, P.242

[38] Depo. Dr. Murphy, P. 177-178, 219, 223, 241-242, 342-343

[39] Depo. Dr. Murphy, P. 219, 260, 342-343

[40] Id., P.156, 260, 270

[41] From the documents I have so far reviewed, it appears that either Ossawatomie State Hospital or perhaps Lamed Hospital are the appropriate forensic psychiatric facilities in the State of Kansas

their patient to a safe and medically appropriate environment, whether as a result of medical injury (as was in fact done when Mr. Richard was transferred to St. Francis after his beating), or when the conditions of confinement coupled with mental illness places the inmate in danger to himself or others. **[*31]**

Dr. Murphy's deposition reveals that he understood virtually nothing about this procedure and had felt no need to learn about it, let alone any need to respond to an inmate's refusal of needed treatment. At his deposition, he acknowledged that Edgar Richard was so mentally impaired that he was treatment-decision incompetent, [42] and in urgent need of treatment with an antipsychotic (Prolixin), and that he was non-compliant with taking it. [43] However, the only thing he could point to as his "response" to this non-compliance was the Order to have Edgar evaluated regarding his competence to stand trial. Dr. Murphy somehow tried to take credit for this effort, even though it was put forward by the District Attorney's office, and had nothing to do with him or his mental health treatment at all. Moreover, he was confusing two issues -- competency to stand trial versus capacity to make decisions about one's medical treatment. The medical situation required an evaluation of treatment-decision-competency, an evaluation that should have been initiated by Dr. Murphy, the psychiatrist in charge. It was the underlying criminal complaint that required a competency-to-stand-trial evaluation, **[*32]** an evaluation that might or might not only then result in an evaluation whether Mr. Richard could be treated over objection.In his deposition, the Probate Court Judge Ballinger, explained how entirely different these two issues are dealt with under Kansas law. Concerns regarding competence to stand trial are brought to the Criminal Court by the prosecuting or the defense attorney. On the other hand, when a concern is raised that an individual lacks capacity for self-care, the concern is brought before the Probate Court, which will hear medical evidence and then has the authority to issue a "Care and Treatment Order" authorizing the treating physician to become a substituted decision maker, along with a "Transport Order," ordering the individual to be transported to an appropriate setting (usually, a hospital; in Mr. Richard's case, this would have been to Osawatomie State Hospital - or possibly **[*33]** St. Francis - for stabilization. Judge Ballinger had no record or recollection of either Dr. Murphy, or Dr. McNeil, or anyone from ConMed, ever inquiring as to the procedure, never once filing a Care and Treatment Petition. [44] Dr. Murphy, Dr. McNeil, or Conmed simply needed to order that Edgar Richard, Jr. be transferred for evaluation to a psychiatric hospital where the Care and Treatment Petition could be filed. [45] In fact, Sedgwick County Jail, General Order 117.01, on the subject of Mental Health Services, clearly states their internal procedures require, "If the situation should arise that the individual cannot be treated within the facility, then arrangements will be made to provide appropriate care..." [46]Dr. Murphy further claimed that a person in prison cannot be treated without consent, **[*34]** while a person in the free world can be. [47] As Judge Ballinger noted, this is simply untrue. In his deposition, Dr. Murphy contradicted his own professed inability to effect psychotropic medication treatment over objection. At one point he claimed that he had no power to decide whether Edgar Richard was competent to decide whether he needed treatment for his mental illness, yet he also acknowledged that he himself in fact had just a few months previously (March 2007) during a period of incarceration, made a treatment decision competency evaluation regarding Mr. Richard's mental competence to refuse surgical treatment of his recently diagnosed colon cancer. [48] In his deposition, he demonstrates no concern whatsoever about the discrepancy between these two statements.Dr. Murphy claimed that he received no information whatsoever from ConMed regarding the appropriate response to medication refusal. **[*35]** [49] There is a Conmed policy on the subject, which states, "An inmate's refusal to take a medication will be documented on the MAR and a medication refusal form will be completed for that inmate and signed by the inmate as well as the

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[42] Depo. Dr. Murphy, P.150-155

[43] Depo. Dr. Murphy, P.79-83, 93-94, 95, 100, 246-248, 304-305, 345-325

[44] Depo. Judge Ballinger, P.53-56, 62-63, 85-86

[45] Conmed Records (010069,010116); Depo. Murphy, P.93-94

[46] Sedgwick County Jail, General Order 117.01, Mental Health Services (SG4901-4902)

[47] Depo. Dr. Murphy, P.81-82, 85-86

[48] Id., P.79-83, 96-97, 98-99, 106, 127-128, 300-301, 302

[49] Id., P.156, 264-267

medical staff. If the inmate refuses to sign, the correctional staff will witness the refusal and sign as a witness..." [50] Dr. Murphy was then questioned about a ConMed policy that required the approval of someone from "corporate," someone hundreds or thousands of miles away from the jail, before treatment over objection could be employed. His contract apparently included that information, and he signed onto it, but he apparently had not even read it. Indeed, he acknowledged that during his entire tenure at Sedgwick Jail, he never had any contact at all with this person from "corporate". [51] He evidently never attempted to get help for a treatment-decision-incompetent inmate. Instead, once the mentally ill inmate was placed in segregation, it apparently made no difference to Dr. Murphy if that inmate massively deteriorated. **[*36]** In his deposition, Dr. Murphy admitted that he had developed no procedure to ensure that he would be informed when an inmate was refusing his medication, and he in fact knew nothing about how or even whether medication refusals would be documented. [52] He was not even familiar with the MAR (Medication Administration Record), the log that recorded what medications were actually administered. [53]Dr. Murphy also was strikingly ignorant about his authority to administer medications over objection in urgent circumstances. He acknowledged that he did indeed have the power to order such medication, but then at one point in his deposition, he inexplicably claimed that he could administer such emergency medication only once every 72 hours. [54] This assertion squarely contradicted the actual practice of his physician assistant -- authorizing that **[*37]** such medication could be administered up to every six hours as needed. [55] Not only did Dr. Murphy not know the extent of his authority in this regard, his deposition revealed that he did not even know what his own assistant was doing -- an explicit abdication of his responsibility to actually supervise his "assistant."Dr. Murphy actually contradicted himself in his responses to inquiry about Edgar's medication non-compliance. During his deposition, inquiry was made regarding his contact with his patient while Edgar was hospitalized after the beating, at a time when his patient was too injured to even communicate, let alone consent to treatment. Despite quite explicitly not getting his patient's permission, Dr. Murphy ordered that Edgar receive injections of long-acting Prolixin. In attempting to justify his decision, he claimed that he had a good relationship with Edgar, and so he knew that Edgar would accept these injections. [56] But if he was so confident **[*38]** of his good relationship with his patient, and his ability to lawfully medicate him, why when Mr. Richard was incarcerated did he not simply go down to Edgar's cell and talk with him in order to elicit his cooperation or to decide that he needed to order that medication be given involuntarily? The obvious answer is that Dr. Murphy simply made no effort; he did what was most convenient for him. When attempting to elicit cooperation took effort, he did not try. When Mr. Richard was simply physically unable to resist, Dr. Murphy ordered that the medication be administered. Together, these two decisions cannot be reconciled as reflecting concern for his patient. They reflected only Dr. Murphy's effort to make his work as easy as possible.In her statement, Ms. Collins described the deterioration of care under ConMed's watch: "[We] put someone on a suicide watch and the response was disappointing. ConMed was not concerned. Their attitude **[*39]** was 'OK,' we will be down in a day or two. I can think of no excuse for ConMed not taking my reports seriously. … There was nothing we could do … and it was a waste of time to complain. After Edgar Richard was beat by Diaz, ConMed never put on a program about the incident or why it happened or how to reduce the chance of a similar thing happening again. … no senior official ever reprimanded the deputies. I knew that the custom of ridiculing mentals was firmly ingrained and I didn't buck the system." [57] She also restated this in her deposition. [58]According to Ms. Collins, the attitude towards the housing and treatment of mentally impaired inmates changed when ConMed took over: "It was the routine practice of the Sheriff's Department and ConMed for those (the mentally impaired)

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[50] Conmed Operations Manual (000247)

[51] Id., P. 233-235

[52] Id., P. 266, 267

[53] Id., P. 265

[54] Id., P. 107

[55] Conmed Chart (010116)

[56] Depo. Dr. Murphy, P.85; Dr. Murphy Consult 02/22/08 (130908-130909)

[57] Stmt Sgt. Collins 05/09/12

[58] Depo. Sgt. Collins, P.34-36

prisoners to be judged by either detention staff or ConMed to 'need' to be placed in administrative segregation. … If a patient in administrative **[*40]** segregation acted 'weird' or was 'talking incoherently' or displayed bizarre behavior, that was nothing a deputy would or should be concerned about, because it was the custom and routine to ignore it because the person was already on administrative segregation or a racked watch. The times I called ConMed to talk to them about a mentally ill person on a racked watch … they would tell me there was nothing could do or they would say we will be down in a few days. There was no concern even for a suicidal person. The solution was locking them up in a racked watch." [59] Ms. Collins expands upon this in her deposition. [60]Ms. Collins describes this same attitude of indifference in regard to the administration of medication in urgent situations: "I know that prisoners with mental illnesses were routinely given medication by injection against their will for their safety and the safety of others before ConMed arrived on the scene. After **[*41]** ConMed took over it became the custom to not provide those injections. It became the custom to just house them in a racked watch cell. Prisoners would get worse mentally and nothing was done under ConMed." [61]Multiple Conmed employees testified no one on behalf of Conmed provided training in dealing with mentally ill inmates. [62] Further, almost universally the Jail staff testified they received no training on safely housing and interacting with mentally ill inmates. [63] In addition to the previously mentioned testimony by Dr. Murphy that it was "common knowledge" that Edgar Richard, Jr. was abused by fellow inmates, Cassie Leu and Andrea Skelon, testified it was well known throughout the jail that mentally ill inmates were picked on and referred to as "mental," "psycho," "skitzo" and "jackass." [64] Former Conmed employee Jennifer Ward stated that when an inmate was placed on psych rack watch nothing was ever done if they acted crazy. [65] Lt. Evans testified an inmate **[*42]** up all night screaming and yelling doesn't mean they are a danger to themselves or others and can act as bizarre as they want on a racked watch. [66] The lack of education and training was thus severely detrimental to the health and safety of mentally ill inmates, including Edgar Richard, Jr. **[*43]**

4.4 Dr. Murphy's Role in Caring for the Mentally Ill Incarcerated at Sedgwick County Jail. The Need to Actually Talk to the Patient.

According to several deponents, including Dr. Murphy, there were on average about 300 inmates at the jail with mental illness. [67] Dr. Murphy was the only psychiatrist on staff. The buck stopped with him; he was ultimately responsible for the welfare of all of these inmates. It was a formidable responsibility.

ConMed and Dr. Murphy agreed contractually that he would work all of four hours a week to meet that responsibility. [68] And no training would be provided about the special issues involved in treating incarcerated patients. It was a contractual agreement that **[*44]** was basically cynical in nature, an invitation for chaos and

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[59] Stmt Sgt. Collins 05/09/12

[60] Depo. Sgt. Collins, P.102-105

[61] Id.; Stmt Sgt. Collins 05/09/12

[62] Depo. Barnt, P.31-32, 44-46, 56-57, 82-83, 85-87; Depo. Woutzke, P.10-12,30, 51-53; Depo. Armstrong, P.15, 67; Depo. Leu, 8, 45, 56, 72; Depo. Murphy, 220-223, 260, Depo. Novak, P.182, 192; Depo. Fletcher, P.12, 14-17, 41, 90-91, Depo. Hall, 49; Depo. Skelton, 24-25, 41-42, 48, Depo. Wolf, P.26.

[63] Depo. Lt. Linzy, P.9, 23, 28, 41-43; Depo. Cpt. Maxwell, P. 8, 14, 18, 20, 32, 104, 105, 107; Depo. Deputy Nelson, P. 30, 121, 128, 133, 134; Depo. Cpt. Bragg, P.28, 34-35, 41-42, 63; Sgt. Burke, P. 39-40, 46, 48, 61-62, 65-67, 143, 69, 72-73; Depo. Deputy Diaz, P.150-152, 156, 161; Depo. Lt. Evans, P. 14, 24-26, 37-38, 44, 49-50, 55, 58-59, 61; Depo. Sgt. Freeman, P. 12-13, 24, 94-96, 105-107, 185; Depo. Sheriff Hinshaw, P. 118, 124, 128, 183-184; Depo. Major Kurtz, P. 8, 39-40, 42, 47, 62, 91, 130; Depo. Former Sheriff Steed, P.94-95; Major Oliver, P.24-25, 88

[64] Depo. Leu, P.50-51; Depo. Skelton, P.47-48

[65] Stmt Jennifer Ward 04/22/12

[66] Depo. Lt. Evans, P.65-67

[67] Depo. Major Kurtz, P.12; Depo. Dr. Murphy, P.215; Depo. Undersheriff Stover, P.62-63

[68] Depo. Dr. Murpy, P.26, 35, 160, 163, 345

grossly inadequate treatment. Dr. Murphy accepted it, and then in his deposition repeatedly hid behind it as an excuse for why he could not do more than he did.In his deposition, Dr. Murphy also admitted that the mental health staffing under him was inadequate for "psychotherapy" -- for actually talking with the patient, getting to know him, creating a trusting relationship with him, understanding what he felt and believed, and hence why he did what he did. [69] Indeed, during the course of Edgar Richard, Jr.'s incarceration at Sedgwick Jail, there is no evidence that anyone attempted to know him, to connect with him, to help him feel safe. Instead, there is plenty of evidence of harassment and abuse against him, by both other inmates and jailers as well. [70] **[*45]**

In his deposition, Dr. Murphy claimed that he had no reason to attempt to know what was going on inside Mr. Richard's mind during his incarceration; he already "knew" him, and, "it was just Edgar being Edgar". [71] But Edgar Richard was not a monolith, a never-changing statue. He was a man capable of being bizarre, verbally hostile -- insane. But he was also a man capable of being cooperative, friendly, attracting care and kindness. His mental state varied dramatically, as is quite typical of individuals with serious mental illness. And there were inevitably reasons why his mental state would fluctuate so wildly. After his beating, when he was transferred to the Wichita Nursing Home, he responded dramatically to the kindness and respect apparently shown him there, and became "a model patient". [72] Well, that, too, was "Edgar being Edgar". And Dr. Murphy never saw it as his responsibility to help Edgar get to that happier place.At **[*46]** some time prior to Mr. Richard's October 31, 2007, incarceration, Dr. Murphy had prescribed Edgar a sleeping medication -- Trazodone. [73] Was it effective? Did it work? He had no idea, never inquired. [74] In fact, during his incarceration at Sedgwick Jail, Edgar had long stretches of no sleep at night -- when he would scream and holler and enrage other inmates in his tier whom he thus deprived of sleep. [75] In his deposition, Dr. Murphy expressed no sense of responsibility to find out whether the prescriptions he so blithely wrote or endorsed were actually taken or actually worked. [76]How could Dr. Murphy acquire information regarding the mental status of the inmates under his care? Talking with them was one means he discounted as beyond his responsibility. But **[*47]** there were other ways. Often, the most detailed information about inmate behavior is found in correctional staff logs and incident reports; any reasonable attempt at evaluating an inmate's mental state should include a review of these documents. Yet in his deposition, Dr. Murphy revealed that he did not even know that such documents existed, let alone that he had read any of them. [77] And once again, he blithely claimed that such review would have been beyond the scope of his responsibility. At the same time, paradoxically, he claimed that the deputies were his "eyes and ears". [78] But he did know of their record-keeping; he did not know whether deputies were actually expected to document or report bizarre behavior to mental health staff, and he did not know that the deputies received no training that would help them recognize and describe such worrisome behaviors. [79] Deputy

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[69] Id., P.158-159

[70] Interview Leu (SG536); Interview Deputy Nelson (SG856); Depo. Murphy, P.242; Depo. McCoy, P.19-20, 170-171; Depo. Beans, P.32-33, 39-40, 47-49, 86, 143-144; Stmt Darby (B04175-B04176); Stmt Anderson (B04561-B04565); Stmt Leal-Anderson (B05031); Stmt Deputy Nelson (SG700-SG772);Stmt Gaston (B04381-B04382); Stmt Kraai (B05020); Depo. Beans, P. 32-33, 39, 40, 47-48, 143-144

<70> Depo. Beans, P.86; Stmt Sgt. Collins 05/09/12

[71] Depo. Dr. Murphy, P.304-305

[72] Stmt Hess 07/09/09 (A25000)

[73] Conmed Chart (010114)

[74] Depo. Murphy, P.125

[75] Interview Darby (B04175-B04176); Interview Anderson (B04561-B04565); Interview Golston (B04381-B04382); Interview Kraai (B05020-B05025)

[76] Depo. Murphy, P.73, 125

[77] Id., P.211

[78] Id., P.332

[79] Id. P.260, 262

Nelson testified there was no reason to report bizarre behavior because "he's already on a racked watch. What would we say, he's acting weird?" [80] **[*48]**

In addition to his facile claim that the deputies were his "eyes and ears," Dr. Murphy also hid behind the proposition that he was part of a mental health "team," that included Michael Hall, a Physician's Assistant. [81] Unfortunately, Mr. Hall's attitude towards his responsibility was no anodyne to Dr. Murphy's blindness to his own professional responsibilities; indeed, Hall's attitude was no better. [82]In his deposition, Mr. Hall admitted that he did not perceive his job as being concerned whether the mentally ill patients under his care were being ridiculed or abused. He further admitted that he had never made any effort to remove an inmate from a caustic environment. [83]Mr. **[*49]** Hall had received no training regarding the psychiatric effects of solitary confinement on mentally ill inmates, and expressed no concern about his ignorance of the matter. [84] He also implicitly expressed his satisfaction with the practice of keeping mentally ill inmates locked up in racked watch and allowing them to deteriorate while there, stating for example that a schizophrenic patient did not present any serious medical need if were grossly psychotic - "talking gibberish" - but could "live" despite a lack of medication or any other psychiatric treatment. [85]Yet exactly what mental faculties did Mr. Hall think were required in order to "live" on racked watch? Apparently in his opinion, "living" is adequate even if it is living in one's own filth, yelling and screaming day and night, engaging in other bizarre behavior and being preoccupied with psychotic delusions. In his deposition, Mr. Hall even revealed that he -- supposedly the point person in **[*50]** Mr. Richard's treatment -- was not even aware that Edgar had during his incarceration become delusionally preoccupied that he was the "Black Jesus". [86]Mr. Hall endorsed the idea that other than medication, racked watch "treatment" consisted only of "monitoring." [87] But "monitoring" is utterly useless unless there is an expectation of doing something if the observations reveal a worsening of the inmate's mental state. And Mr. Hall revealed a similarly cavalier attitude about medication administration and medication refusals. He initially ordered medications for Mr. Richard on November 6, 2007, but did not bother to see Mr. Richard until six weeks later, on December 18, 2007. [88] There are two critical problems with this rather indifferent approach: First, there may be reasons to not simply continue a previously prescribed regimen; it may have been ineffective (after all, Mr. Richard was psychotic upon arrival at the jail), or it may have caused unpleasant side effects (which might lead **[*51]** to non-compliance unless the issue was addressed between patient and prescriber, with appropriate change in the regimen.) Second, medication by itself does not "treat" mental illness. It can only work if the patient feels safe taking it -- and that requires some sense of trust and connection between patient and prescriber. If one reviews the whole Breakthrough Club record, it becomes so clear how much can be done when a patient trusts his providers. But without that trust, there will be fear, paranoia, withdrawal and refusal, deterioration and damage.And what would happen when that occurred -- when the patient was not cooperative, not taking his medication? Mr. Hall knew nothing about assessing whether a patient lacked the capacity for his own care and treatment, never inquired and never intervened. [89] Of course, Dr. Murphy and Conmed did nothing to train him, even though the need for training was open and obvious. **[*52]**

4.5. Conclusions Concerning Liability.

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[80] Depo. Deputy Nelson, P.121-122, 132-133

[81] Id., P.77, 79, 80, 262, 307, 345, 348, 350, 356-357

[82] Depo. Hall, P.49, 54, 97-98, 99-100, 134, 135, 141, 177

[83] Id., P.177

[84] Depo. Hall, P.49-52

[85] Id., P.54-55

[86] Id., P.166

[87] Id., P. 52-54

[88] Conmed Chan (010114, 010116)

[89] Depo. Hall, P.101-102

It is widely accepted that there is an urgent need for adequate mental health services in our jails and prisons, and that there is a far higher incidence of mental illness -- including serious and chronic mental illness - among those incarcerated than in the public at large. Sheriff Steed and then Undersheriff Hinshaw bad been aware of the need for better mental health provisions in the Sedgwick County Jail for years. In November of 2003, an evaluation of the medical services of Sedgwick County Sheriff's Department was conducted by Rebecca Craig, RN, BA, MPA. Her report noted that the Jail was responsible to ensure that inmates are provided appropriate and timely care, and described multiple deficiencies in Sedgwick County Jail, including a lack of mechanisms for review and oversight of health services. [90]

Ms. Craig's evaluation revealed deficiencies concerning continuity of care, staff turn-over **[*53]** and the fact that the system was not addressing needed counseling and supportive services. She expressed concern that there was no onsite psychiatrist and highlighted the Jail's need for active involvement of the most highly trained and skilled clinicians to clinically evaluate inmates who were responding poorly. Ms. Craig noted the Federal Court's conclusion that the psychiatrist is ultimately responsible for mental health services, and concluded that there was a need for at least a "half time" psychiatrist at Sedgwick County Jail. [91]The report also noted that correctional officers must play a key role in identifying, monitoring, and managing inmates with mental illness, since they are the individuals with by far the greatest opportunity to observe the imnates, and thus advised that officer training regarding mental illness was a critical need. She recommended annual officer training regarding the identification and management of mentally ill inmates, with further recommendation **[*54]** that the Jail identify course objectives, utilize course outlines, sign-in rosters and post-tests in order to ensure that officers actually attend and learn this material. Ms. Craig provided as example copies of such training materials from the San Mateo County Sheriff's Department. [92] The evaluator stressed that officers must play a critical role as observers or inmate behavior and emotional response, but that in addition to training as to what to look for and report, such training also must include clear training regarding the procedure for sharing the information with the nurses, mental health practitioners and psychiatrists. [93]The evaluator expressed concern about the violence and psychiatric decompensation occurring in the Jail, and suggested the Jail engage in serious consideration of establishing a mental health housing unit staffed with specially trained officers to accommodate those inmates unable to function in the general population." [94] The evaluator **[*55]** likewise recommended that the Jail develop a multidisciplinary committee to identify deficiencies and to develop correction action plans regarding use of force, use of restraints, monitoring suicidal inmates, review of deaths, suicides, and suicide attempts, outbreaks of illness and inmate grievances. [95] One wonders what the report would have stated if they were aware of the long standing practice of humiliating and abusing the mentally ill and disabled.Over the course of my professional career, I have learned about, written about, and testified about many instances of abuse of prisoners in jails and prisons. But I do not believe I have ever before learned of a system that was so deeply corrupt through the chain of command so that the ridicule and abuse of mentally ill inmates was entirely open, obvious and notorious. In my view, it is a reflection of something even beyond a lack of concern; it goes deeper -- into a culturally normative attitude of sadism towards a **[*56]** terribly ill, terribly vulnerable population.

The Sheriff's Department retained ConMed, the low bidder on its RFP, as the mental health provider for the Jail. But then Sheriff Steed and then Undersheriff Hinshaw took no steps towards oversight of the system, no steps to ensure that despite its low bid, ConMed was providing proper care and treatment of the mentally ill. ConMed's greatest selling point was that it would be cheaper than what came before. Ms. Collins points out in her deposition how treatment changed dramatically when Conmed took over the Jail's health services. [96]And it was cheaper. [97]

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[90] Evaluation of Medical Services (A14128-A14220) (A14152)

[91] Id. (A14138-A114144)

[92] Id. (A14140-A14141)

[93] Id.

[94] Id.

[95] Id. (A14157)

After all, with whatever salary it was willing to offer its potential employees, it remained seriously understaffed during the time Mr. Richard was incarcerated there. [98] In a sworn affidavit in another litigation regarding ConMed, Nurse Dana Anderson stated that the clinical staff were discouraged from providing medical services in order to keep costs down. [99] **[*57]** ConMed paid a grand total of $ 500 a week ($ 125/hour x 4 hours/week) for all of the psychiatric services needed for a mentally ill population of at least 300 people. [100] Dr. Murphy's four hours a week contract to provide services created only a paper thin illusion of mental health care; it could not have been designed to provide more than this. And from his deposition, it becomes clear that Dr. Murphy had no problem with this; whatever he did or didn't do during those four hours a week, he would earn his $ 500/week from ConMed. Interestingly, his efforts on behalf of the inmates at Sedgwick Jail did not even rate a mention in his curriculum vita as presented in his applications for medical license renewal. [101] **[*58]**

As outlined in my report above, ConMed provided no training of correctional staff regarding mental health issues, even though by one estimate, 60% of the inmates at Sedgwick had some form of mental illness, and even though Dr. Murphy claimed that they were his "eyes and ears" (albeit he did not even know that there were records he was supposed to review in order to glean any information from these "eyes and ears"). [102]ConMed did not bother to train Dr. Murphy about the legal process to obtain treatment without consent. In his deposition, Dr. Murphy revealed he had no idea what was entailed -- oblivious to the distinction between the criminal court's jurisdiction regarding competency-to-stand-trial with the Probate Court's power to issue a and Care and Treatment Orders; he apparently had no idea of this latter procedure -- the appropriate one, the one that he could have initiated. He was also clearly ignorant of the Jail's policy that arrangements would be made to transfer inmates **[*59]** to provide appropriate care if it could not be provided within the facility.

ConMed did not train Dr. Murphy about the documents he could review (e.g. the logs, the Medication Administration Reports, etc.). But it made no difference; although the MAR's would reveal when an inmate was refusing his psychiatric medication, Dr. Murphy revealed no interest in learning about such refusals. And other than "logging" the refusal, nothing was done -- no attempt to talk with the patient, no attempt to restore trust and compliance, no willingness to learn of or engage in the process to obtain a Care and Treatment Order where such was indicated. Well, if there was no need to act on what might be learned, then one supposes there was no need to know that one could learn it. And in any event, it is a charade to think that with 300 patients and 4 hours a week, he was going to engage in any proper evaluation and review. These facts demonstrate a complete lack of concern about the professional responsibility he accepted in signing the contract with ConMed -- namely, providing access to adequate mental health services for mentally ill inmates such as Edgar Richard, Jr.

And it is fairly shocking **[*60]** that if Dr. Murphy had wanted to obtain treatment over objection, he would have first had to get permission of some administrator at "corporate" -- hundreds or thousands of miles away. A physician has a duty to exercise his professional judgment on behalf of his patient; he cannot abdicate that responsibility to someone who has no expertise, who has not even met the patient. -- But again, it ultimately mattered little. In his deposition, Dr. Murphy revealed that he had never even attempted to obtain treatment over objection, had never once spoke with this phantom person from "corporate." [103]The practice of placing disturbed mentally ill inmates in solitary confinement and then doing nothing for them except "monitoring" and "logging" is unconscionable. ConMed revealed that it knew that such confinement would likely cause psychiatric decompensation. But its only response

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[96] Depo. Sgt. Collins, P.101

[97] Media Release -- Conmed's 1 Year Anniversary

[98] Amendment to Service Agreement (224-226)

[99] Dana Anderson, Affidavit in Price v. City of Witchita, U.S. Dist.Ct, Kansas, Civ. # 07-1354-MLB

[100] Independent Contractor Agreement (Depo. Ex. Murphy # 24)

[101] Depo. Murphy, P.17-22

[102] Id., P.211

[103] Depo. Murphy, P.233-234

was a policy of increased "monitoring" and filling out forms. But the forms are absent from Edgar Richard, **[*61]** Jr.'s records, and ConMed did not trouble to ensure that they were in fact filled out, nor that its psychiatrist, Dr. Murphy, even knew of their existence. And deposition evidence makes it quite clear that ConMed did nothing to teach its staff -- including Dr. Murphy and Mike Hall -- about the likely effects of such confinement.

As aforementioned, there are voluminous statements and testimony that ConMed failed to provide any education or training to the correctional staff regarding the evaluation and response to mental illness among the inmates at Sedgwick. But they failed even to train the mental health staff at the Jail about some very basic issues:

In her deposition, Mental Health Therapist Karen Barnt testified that she observed mentally ill inmates ridiculed, but ConMed provided no instruction regarding appropriate practices in dealing with the mentally ill inmate. There was no policy or custom on how to deal with an inmate on racked watch who was displaying bizarre behavior, not even how often the inmate should be seen. [104] **[*62]**

In his deposition, ConMed Physicians Assistant Charles Fletcher acknowledged that ConMed had provided him no education or training regarding the evaluation and response to mental illness in the Jail, yet in May 2008 he wrote orders for psychiatric medication for Mr. Richard. He also acknowledged that he knew nothing about medication over objection, or the MAR Form, or even whether there was any procedure by which deputies could reach him if there was a psychiatric problem. Indeed, despite having written the orders, he admitted that he never even knew that Mr. Richard was mentally ill; there simply was no coordination at all between the medical and the mental health staff at the Jail. [105]In her deposition, Certified Nurses Aide Cassie Leu testified that ConMed provided her no training or education regarding mental illness in prison. It was common for the mentally ill to be insulted - "mental", "psycho", "skitzo", "jackass". It was well known that **[*63]** some of the mentally ill were not in touch with reality, and that some "were left to wither away in administrative segregation." She had no idea whether there was any response to medication refusal; all she knew was that when an inmate refused his medication, she was to put an "R" on the MAR Form. [106]In conclusion, the evidence demonstrates that throughout up and down the chain of command, there was a pervasive pattern of ignoring the needs of the mentally ill inmates at Sedgwick County Jail.

The following statements are made to a reasonable degree of medical certainty:

I conclude that the decisions and behavior of ConMed and of Dr. Murphy manifested a complete failure to respond to the open and obvious serious mental health needs of mentally ill inmates at the Sedgwick County Jail whose care they were responsible, a complete lack of action to take any reasonable measures to address the deficiencies and that said conduct was **[*64]** the direct cause of Mr. Richard's psychiatric deterioration during his October 2007 - February 2008 incarceration in the Sedgwick County Jail.

Moreover, the abuse and ridicule of the mentally ill at the Jail was so open and notorious that the mental health staff could not help but be aware of it. Yet again, Dr. Murphy and the other ConMed staff did nothing about it, nothing to attempt to protect their patients from the ridicule, verbal and physical abuse that would inevitably worsen their individual inmates psychiatric condition and increase their suffering. I conclude to a reasonable degree of medical certainty that Mr. Richard's psychiatric condition and suffering worsened because of this failure of ConMed staff and Dr. Murphy.

I further conclude that ConMed decision to contract for only four hours a week of psychiatric coverage at the Jail reflected demonstrated a complete failure to adhere to its responsibilities, as did Dr. Murphy's willingness to accept this clinically untenable position.

I further conclude that ConMed's failure to train correctional staff about mental illness, and its failure to train Dr. Murphy and its other staff about the particular issues **[*65]** encountered in a jail setting (e.g. the toxic effects of

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[104] Depo. Barnt, P.18, 29-30, 56-57

[105] Depo. Fletcher, P.14, 18-20, 24-25, 51, 80

[106] Depo. Leu, P.8, 45, 48-49, 51, 56,61, 64, 70-71, 72-74, 116

solitary confinement, the procedure for obtaining treatment over objection, the records that would help track patient status and compliance with medication, etc.) likewise demonstrated complete disregard to the mentally ill and disabled inmates for whom they were responsible, including Edgar Richard, Jr. And Dr. Murphy's lack of interest in knowing about these things likewise reflected his lack of concern towards his patient's safety and well-being.

Moreover, as Mr. Richard psychiatrically deteriorated, he became an increasing target for ridicule and abuse by both inmates and staff. Indeed, his psychotic behavior became fairly noxious to those around him: His cell reeked of urine and other noxious odors. He would urinate onto the floor at the cell door, causing urine to puddle on the tier. And he would keep others up all night with his yelling and banging. This was an explosive situation, and the failure of Dr. Murphy or the other ConMed staff to do something to help Mr. Richard, and/or to remove him from this setting -- their disregard of his plight - was a moving force in creating his encounter and brutal beating by Deputy **[*66]** Diaz on February 15, 2008.

Mr. Richard's situation urgently needed remedy, especially because it was so ripe for sadistic behavior against him. And there was plenty of it, even before February 15, 2008, when he encountered Deputy Diaz, a guard with a known propensity towards violence, and was beaten senseless.

5.0. Damages.

Diaz' savage beating left Mr. Richard unconscious for several minutes, bleeding profusely, his face smashed, part of his broken jawbone had ripped into his mouth, making it impossible for him to even close his mouth. He was taken by ambulance to St. Francis Hospital, where he remained for three months. He was noted to have multiple facial fractures, the most worrisome of which was the jawbone. On day two, he was taken to surgery where the displaced bone was moved back into its anatomical position and fixed in place. Mr. Richard was thought to have also suffered Traumatic Brain Injury as a result of the beating, causing difficulty speaking (Dysphasia) and cognitive decline. [107] There had also been damage to the innervation of the muscles of the throat and neck; he was unable to adequately breathe on his own, nor was he capable of swallowing; since **[*67]** his epiglottis was not functioning, any attempt at swallowing food or water created the very serious likelihood of aspirating material into his lungs, causing choking and/or an aspiration pneumonia.Thus, at the same surgery, given his compromised breathing, Mr. Richard was given a tracheostomy, and a gastrostomy performed. The latter is a surgical procedure wherein an incision is made through the skin and abdominal wall directly into the stomach; through this hole, a plastic tube (a so-called "G-tube") is inserted, and then the wound is closed around the tube. It is a procedure used to provide nutrition to a patient who is not able to eat and swallow. After the surgery, Mr. Richard was placed in the hospital's Intensive Care Unit in a medically induced coma, intubated and on a ventilator, Despite all these precautions, he still suffered a potentially deadly MRSA pneumonia (pneumonia caused by a massively drug resistant staphylococcus).

By May 25, when he **[*68]** was finally released from the hospital and returned to the Medical Clinic at the Jail, Mr. Richard had been extubated and apparently the tracheostomy had been surgically closed. He was able to breathe on his own. But he still received all nutrition and medication through the G-tube. He had very little control of the muscles of his throat. The innervation to the epiglottis -- the flap that closes to prevent food from going down the trachea -- was still far too damaged. Thus, he could take in nothing by mouth -- no food, no water, no medication. Even while he received nothing by mouth, saliva and other secretions could easily pass into his trachea. He had to continually be suctioned, and the staff tried to teach him how to suction himself, but this proved difficult. And with the nerve damage, he had great difficulty communicating verbally.

He was terribly agitated and often appeared terrified -- shaking and tremulous. He was so distraught about not being able to eat anything, not able to taste any food, not even able to drink some water when he was thirsty. He screamed out to a nurse attending to him: "I'm going to have to live with this for the rest of my life!" [108] In fact, that **[*69]** worst fear did not prove to be accurate. Six months later, in December 2008, he was able to chew and

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[107] Wichita Nursing Center (30001-30003)

[108] Conmed Chart (010092)

swallow, the g-tube was removed and the gastrostomy was reversed.On June 19, 2008 Mr. Richard finally left Sedgwick County Jail. [109] He was transferred to the Wichita Nursing Center, where he was to remain a patient for the rest of his life, until his death from colon cancer on February 1, 2010.It is striking how different his experience was at the Nursing Center from what it had been in the Jail. The deposition testimony of Becca Hess, the Administrator of the Center while Mr. Richard was there, (she left the position in September 2009, a few months before his death) reveals how pleasant and cooperative he could be when he felt safe and cared **[*70]** for. [110]Ms. Hess asked him about what had happened to him. He had some memory of the beating, though it was sketchy. (This would certainly be expected, given that he was beaten into unconsciousness and apparently suffered traumatic brain damage.) What was most obvious though was how much fear he felt when he remembered: "[He] trembled all over from the fear, he would obviously start shaking, his hands, his -- he'd get teary-eyed." [111]She also noticed how much his own helplessness embarrassed and humiliated him. Once she inadvertently walked in on him while he was still struggling to try to eat and swallow food: "He made it abundantly clear that he was very embarrassed by the way he had to eat." [112] **[*71]**

5.1. Opinions Regarding Damages.

It is easy to grasp how much emotional trauma Edgar Richard suffered as a result of the Diaz beating. But perhaps the most disturbing fact in this case is Dr. Murphy's statement: "It's just Edgar being Edgar." Was that meant to mean that it made no difference to Dr. Murphy -- he did not care whether Mr. Richard was friendly, cooperative pleasant, as opposed to being grossly psychotic, screaming, living in his own filth, and being subjected to abuse and humiliation? Or was it meant to mean that although he had seen Edgar in both states, he really did not trouble himself to even think that there was an important difference between the two?

His statement is simply unconscionable. The very experience of having suffered a psychotic episode is itself traumatic; it is absolutely terrifying for an individual to remember how totally helpless and out of control he was. Does Dr. Murphy not realize that Mr. Richard's psychiatric regression in Sedgwick County Jail was the very worst psychotic episode he ever experienced in his life? That he must have experienced shame and fear about it for the rest of his life? That it must have resonated together with **[*72]** the helplessness he felt with the beating and its sequelae?

It is my opinion to a reasonable degree of medical certainty that Mr. Richard's treatment at the Sedgwick County Jail, the catastrophic failures demonstrated in the actions, and in the lack of action, of Sheriff Steed, then Undersheriff Hinshaw and its detention deputies, of ConMed and its staff and of Dr. Murphy, caused Mr. Richard deep and permanent emotional harm -- terror, fear, helplessness, and shame.

Signed this 11th day of September, 2012.

/s/ [Signature]

Stuart Grassian M.D.

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[109] Wichita Nursing Center Chart (A30001-A30003)

[110] Depo. Hess, P.12-13

[111] Id., P.39-40

[112] Id., P.40-41